THE AIR FORCE READY RESERVE STIPEND PROGRAM (AFRRSP) CERTIFICATE OF ENROLLMENT

AUTHORITY: 44 United States Code (U.S.C.) 3101; 10 U.S.C. 133, 2120 through 2130, 8013, and 8032; and Executive Order (E.O.) 9397.
PRINCIPAL PURPOSES: To certify enrollment of an applicant in a professional training program for the critical wartime medical specialties. This certificate qualifies the applicant for financial assistance, in exchange for an enforceable commitment to serve in the Air Reserve Components (ARC) of the United States Air Force as a trained health professional for a specified period of time.
ROUTINE USES: To certify enrollment of an applicant as a requirement for acceptance into the Air Force Ready Reserve Stipend Program (AFRRSP) and to submit stipend transactions to the Air Force Accounting and Finance Center (AFAFC). The social security number (SSN) provides positive identification.
DISCLOSURE IS VOLUNTARY: If the participant fails to provide the information, including the SSN, the USAFR may be unable to approve the applicant's request for health professions financial assistance. This failure could possibly adversely affect the applicant's status in the training program.

I. AIR FORCE RESERVE RECRUITER COMPLETES *(Please type)*

TO: DIRECTOR *(Enter Name and Address of Accredited Institution)*	**FROM:** *(Enter Reserve Recruiting Office and Address)*

_____ **IS APPLYING FOR USAFR SPONSORSHIP IN THE AFRRSP.**

Please complete Section II and return this form to the above office in the enclosed self-addressed envelope. The entry in Section II, Item 3, must be the date the applicant must pay tuition and fees, if applicable. This may be the first day of the professional training program, registration day, or orientation day, whichever coincides with the beginning of the tuition period, if applicable. We appreciate your prompt response. We cannot evalute this individual's application without this completed form.

NAME OF APPLICANT *(Last, First, Middle Initial)*	**SSN OF APPLICANT**	**PERMANENT ADDRESS OF APPLICANT** *(List zip code)*
NAME AND TITLE OF RECRUITER	**PHONE NUMBER** *(Include area code)*	**SIGNATURE OF RECRUITER**

II. DIRECTOR OF PROFESSIONAL TRAINING PROGRAM COMPLETES *(Please type)*

IS STUDENT CURRENTLY ENROLLED? *(If YES, complete items 1 through 4) (If NO, complete items 3 and 4)*	**YES**		**NO**	
1. **DATE ENROLLED IN CURRENT TRAINING YEAR** *(Enter day, month, and year)*				
2. **DATE COMPLETED OR SCHEDULED TO COMPLETE CURRENT TRAINING YEAR** *(Enter day, month, and year)*				
3. **DATE NEXT TRAINING YEAR BEGINS** *(Enter day, month, and year)*				
4. **DATE NEXT TRAINING YEAR ENDS** *(Enter day, month, and year)*				

TRAINING PROGRAM PURSUED

1. **TRAINING PROGRAM DESCRIPTION AND OBJECTIVES**
2. **TRAINING PROGRAM LOCATIONS**

RESIDENT TRAINING FACILITIES AND DATES

NONRESIDENT ROTATION TRAINING

FACILITIES AND DATES

3. **PROJECTED COMPLETION DATE** *(Enter day, month, and year)*
4. **ANNUAL TUITION FEE** *(If applicable)*

I certify the above named applicant has been enrolled (or accepted for enrollment) in this institution to pursue the professional training program indicated, and by pursuing this training program, the applicant does not incur any medical practice obligations other than those required by USAFR.

NAME OF DIRECTOR *(Type First, Middle Initial, and Last)*	**PHONE NUMBER** *(Include area code)*	**SIGNATURE**	**DATE**

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